15 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Wt:	%	Length:	%	Head circ	%

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: [X] INDICATES GUIDANCE GIVEN: At risk ☐ yes ☐ no (if yes a blood lead test is required)

DENTAL SCREENING: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing daily ☐ 1st Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐Feeds self ☐ Breast fed/whole milk ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements _____ ☐ Solids

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: ☐ Says 3-6 words ☐ Says No ☐ Wide range of emotions ☐ Repeats words from conversation ☐ Knows one color ☐ Understands simple commands ☐ Climbs stairs ☐ Walking ☐ Puts objects in container and takes object out of container ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Car seat safety/40#'s/4 years ☐ Gentle limit setting/redirection/safety ☐ Reading/parent asks child "what's that?" ☐ Manage growing independence/defiant behavior ☐ Follow child's lead in play ☐ Offer opportunity to scribble/explore ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Encourage holding ☐ Self calming ☐ Frustration/hitting/biting/impulse control ☐ Communication/language ☐ Social interaction/eye contact/comforts others ☐ Begins to have definite preferences ☐ Other

UUCOMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ TB skin test (if at risk)

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ History of chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Dental ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

Revised November 1, 2007